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Competition in Health Care – the Swiss Experience

Peter Zweifel *

Introduction

The objective of this contribution is to evaluate the strengths and weaknesses of the Swiss health care system after the new Law on Health Insurance (LHI) that took effect at the beginning of 1996. The LHI just barely survived a popular referendum. An important argument of the campaign in its favor had been that health insurance premiums would fall thanks to increased competition between the sickness funds (mutual health insurers). At the same time, the federal government hoped that its budget would be less burdened by subsidies earmarked for health insurance. Neither expectation has been fulfilled, not least because Parliament made the list of benefits covered more comprehensive than ever. Thus, the health share in the GDP has continued to grow, from 9,5 % in 1996 to some 11 % in 2003 (OECD, 2004).

However, data such as these, while popular in political debates, have limited relevance for an economic evaluation. Therefore, the criteria used for evaluation are laid out in the next section. This is followed by an analysis of the first of the three contractual relationships characterizing an insurance-based health care system, i.e. that between consumers and health insurers. It is in this domain that the new Law has brought about several changes. The second contractual relationship to be evaluated is that between health insurers and providers of health care services. The issue here is to what extent insurers are capable and also led by the force of competition to act as prudent purchasers of services on behalf of their clients. The third contractual relationship is that between the insured and healthcare providers. An important aspect here is the freedom of choice of physicians and hospitals, but also the freedom to limit this choice in return for lower premiums. The final section pulls together the partial results to come to an overall assessment of the Swiss experience with competition in health care.

*. Socioeconomic Institute of the University of Zurich. Hottingerstrasse 10, CH-8032 Zurich – Phone +41 1 634 27 20 – Fax +41 1 634 49 87 – pzweifel@soi.unizh.ch – http ://www.soi.unizh.ch

1. Criteria for evaluation

The idea of this section is to apply criteria that have been developed for the assessment of an economy in general to the health care sector. There is general agreement about the following criteria for static efficiency (see e.g. Hirshleifer and Hirshleifer, 1998, ch. 15.2):

1. The goods and services produced should be in accordance with the preferences of consumers. Applied to the healthcare sector, the services provided should match the preferences of the insured, who are assumed to decide about the types of medical care that should be covered by insurance before they are ill.
2. The economy should display technical efficiency. In the present context, the health care services that are provided according to criterion 1 should be produced at least cost.
3. The income distribution should support the attainment of (1) and (2). Applied to the healthcare sector, providers should not be able to enjoy monopolistic rents (by closing markets in particular). Otherwise the resulting prices jeopardize both preference matching and technical efficiency.

Much less agreement exists with regard to a criterion that calls for an equitable income distribution. However, the debate about reform of health insurance and health care centers so strongly around distributional consequences that this ambiguity shall not be taken as a reason to discard this criterion entirely. For the time being, it will be stated as:

4. The distribution of healthcare services and its financing should be "acceptable". The actual evaluation will depend on the standard adopted. One can be satisfied by a nonegalitarian solution that guarantees access to health insurance regardless of income and wealth, without requiring access to health care to be fully equal across the entire income and wealth distribution. Or one can require that use of services or even health status itself be independent of income and wealth (egalitarian standard).

Perfect competition is known to result in the satisfaction of criteria 1 to 3. However, in health care flexible prices like on a spot market would burden individuals in bad health with excessive transaction costs (seeking out a physician and negotiating fees). Indeed, the contractual partners (patients, health insurers, and healthcare providers) may have an interest in fixing fees for a longer period of time to obviate these costs. Therefore, competition here means the freedom of the three contractual partners to choose the partners they prefer and to freely choose the contractual clauses (as long as they are not to the detriment of some third, uncompensated party).

2. Institutional framework

The institutional framework needs to be discussed because it defines the ease with which political decision-makers can limit the contractual freedoms mentioned above. Switzerland has three levels of political authority, with their specific roles in the healthcare sector.

2.1. The confederation

The LHI is a federal law, and thus the confederation is responsible for implementing it. One of the key provisions of this law is a federal subsidy paid to individuals whose premiums exceed a certain share of taxable income. These subsidies are matched by cantonal grants (see below) such that no individual shall pay more than 12 % (in more generous cantons, this level is 8 %) of taxable income. The LHI also has introduced a great deal of choice (to be described below). On the other hand, it also has reinforced central planning by giving the confederation the right to impose uniform fee schedules as well as guidelines for hospital planning (which basically is in the domain of cantonal authority).

Indeed, in 2003, the confederation has introduced the uniform fee schedule "TarMed" for physician services, which replaces schedules that used to be negotiated at the cantonal level. Thus, a set of uniform solutions has been replaced by another at a higher level. In a truly competitive system, however, it is the task of the health insurer to negotiate forms of payment that induce optimal outcomes for their particular clientele. Contract theory suggests several parameters that should be present in an optimal payment schedule (Laffont and Tirole, 1993, ch. 1.4); however, at most two of them seem to be present in the current TarMed formula. Finally, it should be noted that lawmaking at the federal level is constrained by popular referendum, as happened in 1995 with the LHI.

2.2. The cantons

The 26 cantons of Switzerland have primary authority in health policy because they are the main financiers of hospitals. The LHI limits their engagement to 50 % of operating costs, while leaving them responsible for hospital investment. Cantons encourage and sometimes enforce the formation of a cantonal hospital association, with the consequence that health insurers face a monopoly as purchasers of hospital services. They therefore have created their own cantonal association. Hospital payment is uniform within a canton, precluding the possibility of an insurer devising different forms of payment for its own clientele. In addition, should negotiations fail, the cantonal government has the authority

to impose fees. This encourages cantons to engage in quality competition while shifting the additional cost in part to health insurers and through these to consumers outside the canton in question. Incentives for cantons to engage in a division of labor with regard to hospital services are therefore rather weak.

2.3. The communes

The approximately 2,900 communes of Switzerland enjoy a great deal of autonomy in general as they can decide about income taxation. However, in the domain of health care, they are integrated in regional hospital associations that provide part of investment finance but lack final decision authority, which lies with the canton. The main task of communes is to subsidize and also often operate nursing homes.

In sum, the Swiss institutional framework is characterized by a good deal of direct democratic control. This is a precondition for tying the political process to voters' preferences (see line 1 of table 1). On the other hand, there is little pressure to enforce technical efficiency, and negotiations at the association level are not the way to prevent monopoly rents in income distribution. The financing of health insurance is regressive in the sense that high-income insured do not pay the same share of their income as their low-income counterparts. On this egalitarian standard, Switzerland does not attain a high mark (see line 4 of table 1).

3. Relationship between consumers and health insurers

By its very nature, the uniform benefits package does not allow the expression of individual preferences. The LHI brought about a very substantial expansion of mandatory benefits which increases the excess burden for some parts of the population. On the other hand, individuals have free choice among some one hundred insurers without any involvement of employers at all. In addition, annual deductibles are available ranging from 230 CHF to 1,500 CHF (approximately 175 € to 1,000 €). Also there is a bonus option offering a maximum rebate of 45 % after three years without a claim, but with a 10 % solidarity surcharge on the basic premium. Finally, several insurers offer Managed Care alternatives ranging from Preferred Providers options on to gatekeeper systems and actual Health Maintenance Organizations.

Of course, this creates quite a potential for risk selection which may be conducive to technical inefficiency. On the other hand, the premium reductions

granted for the higher deductible, Managed Care, and bonus options are regulated to values far below actual cost savings achieved. So far, no "death spiral" has been observed in that a health insurer actually became insolvent because of adverse selection; however, small insurers with an unfavorable risk structure have continued to merge with larger ones, and one major insurer had to withdraw from a few cantons because it accumulated excessive losses there. Effective 1993, there is a risk adjustment scheme in place, which however is based on age and sex only. Its purpose is to mitigate the strong incentives for risk selection created by the LHI which imposes uniform premiums on a given insurer for all adults enrolled within a given region.

Still, premiums in a given region differ sufficiently between insurers to induce some migration. The switching rate was highest right after the introduction of the new LHI but fell to some 2 percent by 2000. However, there is evidence that it has increased again, to about 5 percent in 2002 (Laske-Aldershof et al., 2004). This is higher than e.g. in the Netherlands with some 2.5 percent, pointing to a comparatively marked degree of premium competition. The price elasticity estimated from aggregate (market share) data is around -0.5 for Switzerland, which is in the same range as the -0.3 to -0.4 values found for the Netherlands.

Uniform premiums of course are not compatible with controlling moral hazard (Zweifel and Breyer, ch. 6.4). Moreover, their distributional merits are ambiguous in that they benefit not only the sick but also the rich and sick to the extent that the demand for health care increases with income. In sum, these considerations may justify the entries in the second column of table 1.

Table 1 : *Evaluation of the Swiss healthcare system*

	Inst. framework (section 2)	Consumers and insurers (section 3)	Insurers and providers (section 4)	Consumers and providers (section 5)	Total (max. = 8)
1. Matching preferences	2	2	1	2	7
2. Technical efficiency	1	0	0	1	2
3. No rents in income distribution	1	1	0	1	3
4. "Acceptable" distribution in health care	1	1	2	1	5
Total (max. = 8)	5	4	3	5	

(Note: 0 = not satisfied, 1 = somewhat satisfied, 2 = fully satisfied)

4. Relationship between health insurers and service providers

First of all, insurers must contract with domestic providers only. In the case of physicians, the LHI obliges them to respect an "any willing provider" clause. However, the LHI contains an exception for Managed Care alternatives. Since 2003, insurers must apply the "TarMed" fee schedule nationwide, which precludes them from negotiating optimal modes of payment for parts of their clientele with groups of service providers in fee-for-service medical care, which still accounts for some 90 % of the market. This is not compatible with the matching of preferences, technical efficiency, or an income distribution without rents.

However, these criteria are violated to an even greater extent by the cantonal restriction that contracts cannot be struck with individual hospitals. Except for fully private clinics, hospitals of a given canton have to negotiate at the association level. Moreover, hospital payment is uniform within the canton, the majority of them still relying on per diems augmented by a fixed payment per case and a few using a DRG-scheme. Of course, this permits inefficient hospitals to survive and to continue offering a broad range of services rather than concentrating on a few specialties. As for the distributional implications, these rigidities have the advantage of preventing insurers from contracting with providers that would attract rich patients only. On the whole, these considerations motivate the entries in the third column of table 1.

5. The relationship between consumers and health care providers

Individuals signing up for a conventional policy have free choice of physician nationwide and free choice of hospital within the canton of residence. However, they also have the freedom to limit this choice in exchange for a lower premium by opting for one of the Managed Care alternatives, which contract with selected physicians only. Health insurers so far have refrained from providing information on physicians or hospitals that would facilitate these choices.

Of course, this freedom creates the suspicion that the actual delivery of health care might be pro-rich. A first indication to the contrary is the finding that the number of physician visits does not depend on immigrant status, employment status or education once health status is controlled for (Winkelmann, 2002). Moreover, the concentration index used by Doorslaer et al. (2002) to reflect the degree of inequality in the provision of health care with respect to income shows

that Switzerland is slightly pro-poor in terms of GP visits, being in the same camp as Denmark, Germany, and Austria (see table 2). In the year 1997 (shortly after the introduction of the new law), there is no evidence of the distribution of GP visits becoming less pro-poor compared to 1982, rather to the contrary. When it comes to specialist visits, the countries of the sample tend to turn slightly pro-rich. Switzerland shares this tendency to a rather lesser degree, with no change visible in 1997, right after the introduction of the LHI.

However, the distribution of poor health is pro-poor in Switzerland and has become even more so after the injection of more competition by the LHI. This suggests that the incidence of ill health continues to be concentrated among the lower income groups, but that this has little to do with the distribution of medical care among income groups. On the whole, the distribution of medical care, while not as pro-poor as in the United Kingdom, is not as regressive as judged by some observers (WHO, 2000), and the increase in competition brought about the LHI of 1996 does not seem to have changed this. Therefore, the entry in the fourth column of table 1 can be justified.

Table 2 : *Concentration indices, around 1996*

	GP visits		Specialist visits		Poor health	
	cM	t	cM	t	cM	t
Austria	-0.0496	-3.45	0.0360	1.83		
Belgium	-0.1023	-8.78	-0.0303	-2.46		
Denmark	-0.0787	-5.24	0.0197	0.72		
Germany	-0.0631	-5.04	0.0150	1.01		
Greece	-0.1257	-8.06	-0.0360	-2.15		
Ireland	-0.1282	-9.39	0.0696	3.02		
Italy	-0.0642	-3.57	0.0205	1.26		
Luxembourg	-0.0883	-5.51	-0.0658	-2.51		
Netherlands	-0.0472	-4.59	-0.026	-1.34		
Portugal	-0.0696	-5.17	0.0959	3.85		
Spain	-0.0908	-8.35	0.0248	1.65		
Switzerland 1982	-0.063	-3.40	0.001	0.09	-0.059	-5.05
1997	-0.069	-5.42	-0.001	-0.03	-0.073	-7.6
United Kingdom	-0.1154	-9.7	-0.0245	-1.12		
Canada	-0.0795	-11.07	0.0009	0.08		

Note: Negative values indicate a pro-poor distribution

Source: Van Doorslaer, Koolman, and Puffer (2002), Leu and Schellhorn (2004)

6. Conclusions

A rough overall assessment can be derived from the entries in table 1. Of course, summing the scores implies fixed and equal utility weights on which one need not agree at all. Still, the total score may indicate what the strengths and weaknesses of the Swiss health care system are. According to the horizontal summation, the criterion of matching preferences is satisfied to a high degree (with 7 out of maximum of 8 points). Swiss consumers and patients are hardly constrained through the institutional framework or contractual relationships in bringing their preferences to bear. But then, there is little reason to believe that those services are produced at least cost. With a score of only 2, lack of technical efficiency is an important weakness of the system. Likewise, there are several cartelistic elements in the contractual relationships that permit rents to persist, creating incentives to perpetuate these conditions that favor the technical inefficiency just noted. Finally, the available evidence suggests that the distribution of health care services (somewhat less of health itself) can be judged acceptable with regard to immigration status, employment status, education, and income (score of 5).

The vertical summation indicates the elements of the system which contribute to the relative strengths and weaknesses found. With 5 points, the institutional framework does not fall too short of the theoretical maximum of 8. The same holds for the relationship between the consumers as patients and health care providers. The contractual relationship between consumers and insurers is a somewhat weaker element in the system. However, the lowest mark (of 3 points) not surprisingly pertains to the contractual relationships between insurers and health care providers. Insurers' function as prudent purchasers needs to be strengthened, but under the important proviso that cartelistic agreements between them are to be suppressed. This constitutes a major challenge for competition policy as long as the TarMed fee schedule as well as the prices of drugs on the uniform formulary continue to be negotiated at the level of the national health insurers' association ("Santésuisse") and hospital rates at the level of cantonal associations.

In 2003, a bill that would have given insurers more freedom in contracting with physicians in the domain of conventional fee-for-service was dropped in parliament. At the time of writing (2004), the federal government again is preparing a revision of the LHI that would relax the any-willing-provider clause with regard to physicians. The other major restriction, the obligation to contract with all the public hospitals of a canton, is not likely to be lifted in the near future. This obligation protects the interests of cantonal governments, permitting them to act like monopolistic owners of "their" hospitals because of their important financing role. Without the cantonal hospital subsidies, health insurance premiums of

course would have to go up, and the simple way to neutralize this increase would be to raise the premium subsidy paid to consumers accordingly. However, this implies that at the current 8 to 12 % threshold of taxable income, the majority of the Swiss population (rather than one-third presently) would receive a subsidy. To avoid moving money from one pocket to another for many individuals, the threshold would have to be increased, to e.g. 18 percent of taxable income. However, at that limit, earning additional gross income would entail such an important loss of subsidy and hence net income that the incentive effects of the scheme, in particular on the supply of labor, could not be neglected anymore.

For a small country like Switzerland, the obligation to limit contracting to domestic providers of health care services, pharmaceuticals, and auxiliary suppliers is also of considerable importance. So far, this "principle of domestic procurement" has been debated in the context of parallel imports of pharmaceuticals only. However, this principle also prevents Swiss health insurers from contracting for physician and hospital services in neighboring areas of France, Italy, Austria, and Germany. First experiences with cross-border contracting are being made in the domain of complementary insurance. The application of non-discriminating procurement rules to the health care sector will remain on the agenda for some time to come.

In conclusion, Swiss politicians and voters are somewhat disappointed by the effects of increased competition in health care. The main reason is that they expected to obtain a given basket of health care services at reduced cost. However, with the high rate of technological change in medicine, this basket changes fast in favor of therapies that are more highly valued and hence fetch a higher price.

This puts increasing pressure on the system to improve its technical efficiency. Cantonal governments have the capabilities but lack the incentive to act. Under the pressure of competition, health insurers have the incentive but still lack the capability to increasingly become prudent purchasers on behalf of consumers. Thus, contractual freedom for insurers in conjunction with the prohibition of cartelistic agreements seems to be the way forward to reap the full benefits of competition in the Swiss health care sector.

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